HealthSourceRI
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF HUMAN SERVICES

APPLICATION FOR

Healthcare Coverage

(and to find out if you can get help with costs)

Use this application to see what healthcare coverage you qualify for:	• Private Qualified Health Plans • To see if you qualify for financial assistance to help pay for healthcare coverage, use the longer form of this application.
Apply faster online	**Apply faster online at www.healthsourceri.com** This application has the same questions that you will see online at our website. There are many pages that repeat, to accommodate larger families. Look for notes at the top of the sections, to see if you can skip the section.
Information you may need to apply:	• Social Security numbers • Birth dates • Passport, alien, or other immigration numbers for any legal immigrants who need healthcare coverage
Why do we ask for so much information?	We need the following information to determine what healthcare coverage you are qualified for. We will keep the information you provide private as required by law.
Send your complete and signed application to:	HealthSource RI HZD Mailroom 74 West Road, Suite 900 Cranston, RI 02920-8413
Get help with this application:	• Online: www.healthsourceri.com • Phone: Call the Customer Support Center at 1-855-609-3304 or 1-888-657-3173 (TTY) • In person: To find in-person application assistance visit www.healthsourceri.com, www.dhs.ri.gov or www.eohhs.ri.gov or come by at 401 Wampanoag Trail in East Providence (Monday to Friday: 8 am to 7pm)

NEED HELP WITH YOUR APPLICATION? Visit healthsourceri.com, dhs.ri.gov or eohhs.ri.gov or call us at 1-855-609-3304. Para obtener una copia de este formulario en Español, llame 1-855-609-3304. If you need help in a language other than English, call 1-855-609-3304 and tell the customer service representative the language you need. We'll get you help at no cost. TTY users should call 1-888-657-3173 (TTY).

Definitions

HealthSource RI: HealthSource RI is a unique resource that connects Rhode Islanders to a range of health insurance options. It provides tools, resources, and information you need to stay informed and healthy. Whether you need insurance for yourself, your family, or your employees, you'll find everything you need to weigh your options and choose the right plan. Our website lets you compare your coverage options side-by-side—in simple language. And our experts are available during extended hours to help you with any questions, concerns, or issues.
Whichever plan you choose, you'll get essential health benefits, including doctor visits, hospitalizations, maternity care, ER visits, and prescriptions. You may also qualify for a tax credit to help pay for insurance. HealthSource RI can also provide information about and assistance with applications for public programs such as Rhode Island Medicaid.

Premium: Your monthly premium is the amount that you pay each month for your health insurance. You must pay your monthly premium on time each month in order to keep your health insurance active. On HealthSource RI, you can have your premium taken right out of your bank account every month. You can also pay with a check or a money order.

Deductible: Your deductible is the amount you owe for certain healthcare services before your health insurance begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered healthcare services subject to the deductible. The deductible may not apply to all services.

Advance Premium Tax Credit (APTC): HealthSource RI offers tax credits to help Rhode Islanders pay for their monthly health insurance costs. These tax credits are based on who is included in your household, and how much income your household earns. An Advance Premium Tax Credit is paid directly to your insurance provider. **Use the longer form of this application to see if you qualify.**

Cost-Sharing Reductions: Cost Sharing Reductions lower the amount of money you spend on your medical care. You will pay less for co-pays, deductibles, and co-insurance when you see the doctor, go to the hospital, or get a prescription. These Cost Sharing Reduction discounts are only available on Silver plans. **Use the longer form of this application to see if you qualify.**

Minimum Essential Coverage: This is the type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, Children's Health Insurance Plan (CHIP), TRICARE and other coverage that covers Essential Health Benefits.

Minimum Value Standard: A health plan meets the "minimum value standard" if the plan's share of the total benefit costs covered is no less than 60 percent of such costs. If you do not have access to any health coverage that meets the minimum value standard, you may be eligible for tax credits to help cover the cost of insurance. **Use the longer form of this application to see if you qualify.**

Individual Responsibility Requirement: Starting in 2014, the individual shared responsibility requirement calls for each individual to have minimum essential health coverage (known as minimum essential coverage) for each month, qualify for an exemption, or make a payment when filing his or her federal income tax return.

Rhode Island Medicaid Program: Public health coverage programs for eligible Rhode Island residents, funded through Medicaid and the Children's Health Insurance Program. The Rhode Island Medicaid program delivers health care through its RIte Care managed care plans for families with children, Rhody Health Partners and Connect Care health care options for adults and elders, and an array of institutional and community-based programs that deliver long-term services and supports. **Use the longer form of this application to see if you qualify.**

Healthcare Coverage Rights and Responsibilities

Your rights for all health insurance programs. HealthSource RI must:

Help you fill out all requested forms. You can contact HealthSource RI for assistance.

Provide interpreter or translator services at no cost to you when communicating with HealthSource RI.

In accordance with federal and state law and U.S. Department of Health and Human Services (HHS) policy, **this institution is prohibited from discrimination on the basis of race, color, national origin (limited English proficiency persons), age, sex, disability, religion, gender identity or political beliefs.** To file a complaint of discrimination, contact HHS. Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.

Your responsibilities for all health insurance programs. You must:

SSN Disclosure. You must provide the Social Security number (SSN) for anyone in your household, including yourself, who applies for health insurance through HealthSource RI, under Federal Law (45 CFR 155.305 and 42 CFR 435.910).

SSNs are used to check identity, citizenship, immigration status and income, as well as to prevent fraud and verify healthcare claims. We also use SSN information with other federal and state agencies, including the Internal Revenue Service, to manage our programs and follow the law.

If requested by the agency, provide any information or proof needed to decide if you are eligible.

Report changes in income, family size or other application information as soon as possible.

Things you should know for all health insurance programs:

There are certain state and federal laws that govern the operation of HealthSource RI, your rights and responsibilities as a user of HealthSource RI, and the coverage obtained through HealthSource RI. By filling out this application, you agree to comply with these laws and coverage obtained hereby.

The National Voter Registration Act of 1973 requires all states to provide voter registration assistance through their public assistance offices. Applying to register or declining to register to vote will not affect the services or benefits that you will be provided by this agency. You can register to vote at http://www.elections.ri.gov/voting/registration.php.

You may ask for an appeal if you disagree with a decision that was made by HealthSource RI regarding your eligibility, you have a right to appeal that decision. Pursuant to EOHHS Rule #0110, "Complaints and Hearings," you may file an appeal of an eligibility determination and the matter will be heard by a hearing officer. You must file an appeal within the 30 day period that begins five days after the date your notice was sent via email (transmittal date) or by U.S. Mail (postmark date) by HealthSource RI. Once you have received the notice, you can request an appeal. The notice contains information about how to request an appeal. Please call HealthSource RI at (855)712-9158 with any questions.

Health Insurance Portability and Accountability Act (HIPAA) restrictions prevent us from discussing the health information of you or any member of your household with anyone, including an authorized representative, unless that individual has power of attorney or you have signed a consent form allowing the disclosure of this information. This includes disclosure of mental health information, HIV, AIDS, STD test results, or treatment and chemical dependency services.

The information that you give HealthSource RI is subject to verification by federal and state sources.

In order to review your Application and to determine whether you qualify to purchase a plan, HealthSource RI must obtain confidential financial and other information from state and federal agencies. This process may also include follow-up contacts from agency staff.

Your personal information will be protected as described in the HealthSource RI Privacy Policy which may be made available to you upon request. You may contact HealthSource RI to request a copy. HealthSource RI is not responsible for administering your health insurance plan. Your health insurance carrier can provide you more information about your benefits. **If you have questions about the terms of your health insurance plan, including what benefits you are eligible for, out of pocket expenses under your plan, and making a benefit claim or appealing a denial of benefits, you should contact your health insurance carrier.** If you are eligible for COBRA following the termination of any health insurance coverage, administering COBRA and providing you the required COBRA notices and election periods is your former employer's or issuer's responsibility.

Do not cancel any current insurance coverage or decline any COBRA benefits until you receive an approval letter and insurance policy, also known as insurance contract or certificate, from the insurance carrier you select. Make sure you understand and agree with the terms of the policy, pay special attention to the effective date, waiting periods, premium amount, benefits, limitations, exclusions, and riders.

Things you should know for qualified health plans:

If you enroll in a qualified health plan through HealthSource RI and you do not provide enough information for HealthSource RI to verify your eligibility to purchase a plan, or if any information you provide is not verifiable, you will have 90 days to provide further information to satisfy HealthSource RI's eligibility requirements. During this time, you should work with HealthSource RI staff to try to provide any missing information or resolve any inconsistencies so that your coverage and applicable costs may be effective as soon as possible.

Premium rates are subject to change based on the health insurance carrier's underwriting practices and your selection of available optional benefits, if any. Final rates are always determined by the health insurance carrier.

Premium rates are for your requested effective date ONLY. If the actual effective date of your policy is different from your requested effective date, the actual cost of your policy may differ from the rates listed on HealthSourceRI.com, due to rate increases or policy changes from the insurance company and/or one or more family members having a birthday. (Rates are highly dependent on age.) The carrier you selected may not guarantee their rates for any period of time until a contract is signed.

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EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
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Application for Healthcare Coverage

Please include yourself; other family members; anyone who is included on your federal tax return, if you file one; Only include your unmarried partner (your boyfriend or girlfriend) if you live together AND you have a child together. If you do not have a child together, do not include your unmarried partner. Also, do not include your roommate. You can complete an application for other people in your family even if you don't need coverage. You do not need to provide SSNs for family members who are not applying for coverage.

1. First Name | Middle Name | Last Name | Suffix (Sr., Jr., I, II, III, IV)

2. Gender ☐ M ☐ F

3. Date of Birth Month:_____ Day:_____ Year:_____

4. Are you applying for Medical coverage? ☐ Yes ☐ No

5. Are you applying for Dental coverage? ☐ Yes ☐ No

6. Do you have a Social Security number? ☐ Yes ☐ No

If you have an SSN, enter it here.

6a. Social Security number (SSN):_____

7. My Name is different on my Social Security card: ☐ Yes ☐ No

7a. If YES, Name on Card: _____

8. First Name | Middle Name | Last Name | Suffix (Sr., Jr., I, II, III, IV)

9. Gender ☐ M ☐ F

10. Date of Birth Month:_____ Day:_____ Year:_____

11. Is this person applying for Medical coverage? ☐ Yes ☐ No

12. Is this person applying for Dental coverage? ☐ Yes ☐ No

13. Does this person have a Social Security number? ☐ Yes ☐ No

If this person has an SSN, enter it here.

13a. Social Security number (SSN):_____

14. Is this person's name is different on his or her Social Security card: ☐ Yes ☐ No

14a. If YES, Name on Card: _____

15. First Name | Middle Name | Last Name | Suffix (Sr., Jr., I, II, III, IV)

16. Gender ☐ M ☐ F

17. Date of Birth Month:_____ Day:_____ Year:_____

18. Is this person applying for Medical coverage? ☐ Yes ☐ No

19. Is this person applying for Dental coverage? ☐ Yes ☐ No

20. Does this person have a Social Security number? ☐ Yes ☐ No

If this person has an SSN, enter it here.

20a. Social Security number (SSN):_____

21. Is this person's name is different on his or her Social Security card: ☐ Yes ☐ No

21a. If YES, Name on Card: _____

22. First Name | Middle Name | Last Name | Suffix (Sr., Jr., I, II, III, IV)

23. Gender ☐ M ☐ F

24. Date of Birth Month:_____ Day:_____ Year:_____

25. Is this person applying for Medical coverage? ☐ Yes ☐ No

26. Is this person applying for Dental coverage? ☐ Yes ☐ No

27. Does this person have a Social Security number? ☐ Yes ☐ No

If this person has an SSN, enter it here.

27a. Social Security number (SSN):_____

28. Is this person's name different on his or her Social Security card: ☐ Yes ☐ No

28a. If YES, Name on Card: _____

Photocopy this sheet to add additional family members.

Contact Information and Address

1. First Name | Middle Name | Last Name | Suffix (Sr., Jr., I, II, III, IV)

1a. Primary Phone Number	**1b.** Secondary Phone Number	**1c.** Email Address (required)
☐ Cell ☐ Home ☐ Work ( )	☐ Cell ☐ Home ☐ Work ( )	

2. HealthSource RI may need to contact you regarding the status of your application and/or request additional information. What is your preferred method of contact? ☐ Email ☐ Paper Mail

3. What is your preferred time of contact for calls? ☐ Morning ☐ Afternoon ☐ Evening ☐ Weekend ☐ Anytime

4. Preferred spoken language (lengua hablada preferida)
☐ English ☐ Español ☐ Português

5. Preferred written language (lenguaje escrito preferido)
☐ English ☐ Español ☐ Português

6. Home Address	Apt/Unit #	City	State	Zip Code
7. Mailing Address *(if different)*	Apt/Unit #	City	State	Zip Code

7b. I currently do not have a permanent home ☐

If you do not have a permanent home you may enter the address of a person you stay with, a homeless shelter, or the nearest DHS office.

Personal Information

8. Ethnicity (Optional) ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ other Hispanic ☐ non-Hispanic

9. Race (Optional) ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian ☐ Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other

10. Are you currently incarcerated? ☐ Yes ☐ No

10a. If YES: Expected Release Date: Month:_____ Day:_____ Year:_____

Citizenship and Immigration Information

You don't need to answer questions 11-15 if you're not applying for coverage.

11. Are you a US citizen or national? ☐ Yes ☐ No

12. If a non-citizen, has this person lived in the U.S. for any length of time prior to 08/22/1996? ☐ Yes ☐ No

13. Please provide information on your immigration documentation

If you have an eligible immigration status, please provide information on your documentation below.

Document Type		Document Number	Expiration(MM/DD/YY)
13a. Certificate of Citizenship: Alien #:	☐	Citizenship Number	Not applicable
13b. Naturalization Certificate: Alien #:	☐	Naturalization Number	Not applicable
13c. Reentry Permit (I-327): Alien #:	☐		
13d. Permanent Resident Card ("Green Card," I-551): Alien #:	☐	I-551 Card Number:	
13e. Refugee Travel Document (I-571) Alien #:	☐		
13f. Employment Authorization Card (I-766) Alien #:	☐	I-776 Card Number:	
13g. Machine Readable Immigrant Visa (with temporary I-551 language). Visa Number:_____ Country of Issuance: _____ Alien Number:_____	☐	Passport Number:	
13h. Temporary I-551 Stamp (on passport or I-94, I-94A) Country of Issuance: _____ Alien Number:_____	☐	Passport Number:	
13i. Arrival/Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services Sevis ID: _____	☐	I-94 Number:	
13j. Arrival/Departure Record in unexpired foreign passport (I-94) Country of Issuance: _____ Sevis ID: _____ Visa Number: _____	☐	Passport Number: I-94 Number:	
13k. Unexpired foreign passport Country of Issuance: _____ Sevis ID: _____	☐	Passport Number: I-94 Number:	
13L. Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20) Sevis ID: _____ Country of Issuance: _____	☐	Passport Number: I-94 Number:	
13m. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019) Sevis ID: _____ Country of Issuance: _____	☐	Passport Number: I-94 Number:	
13n. Other documents or status types Document Description:_____ Alien Number:_____ Sevis ID: _____ Country of Issuance: _____	☐	Passport Number: I-94 Number:	

14. If your name is different on your immigration document, please provide the name on the document:

First Name Middle Name Last Name

15. Are you an honorably discharged veteran or an active duty member in the U.S. military? ☐ Yes ☐ No

American Indian & Alaskan Native Information for You

American Indian and Alaskan Natives may be eligible for special benefits through HealthSource RI.

16. Are you American Indian or an Alaskan Native? ☐ Yes ☐ No **If NO,** skip to Family Member 2 questions, if applicable.

If YES:

16a. Are you a member of a Federally Recognized Tribe? ☐ Yes ☐ No

16b. Tribe Name _____State _____

16c. Have you ever gotten service from the Indian Health Service, Tribal Health Program or Urban Indian Health Program?
☐ Yes ☐ No

16d. Are you eligible to get services from the Indian Health Service, Tribal Health Program or Urban Indian Health Program through a referral from one of these programs? ☐ Yes ☐ No

Family Member 2 - *Skip to page 18 if there is no one else in your family*

1. First Name | M.I. | Last Name | Suffix (Sr., Jr., I, II, III, IV)

2. Does this person live with You, the Primary Applicant? ☐ Yes ☐ No

3. If NO, this person's Home Address	Apt/Unit #	City	State	Zip Code

4. Relationship to You, the Primary Applicant:

- ☐ Brother/sister
- ☐ Uncle/aunt
- ☐ First cousin
- ☐ Son-in-law/daughter-in-law
- ☐ Brother-in-law/sister-in-law
- ☐ Trustee
- ☐ Ward
- ☐ Non-relative caretaker
- ☐ Husband/Wife
- ☐ Domestic Partner
- ☐ Former spouse
- ☐ Son/daughter
- ☐ Stepson/stepdaughter
- ☐ Nephew/niece
- ☐ Child of domestic partner
- ☐ Grandchild
- ☐ Adopted son/daughter
- ☐ Foster child
- ☐ Sponsored dependent
- ☐ Parent
- ☐ Stepparent
- ☐ Guardian
- ☐ Father-in-law/ mother-in-law
- ☐ Grandparent
- ☐ Parent's domestic partner

5. Ethnicity (Optional) ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ other Hispanic ☐ non-Hispanic

6. Race (Optional) ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian ☐ Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other

7. Is this person currently incarcerated? ☐ Yes ☐ No

7a. If YES: Expected Release Date: Month:_____ Day:_____ Year:_____

Family Member 2 - Citizenship and Immigration Information

You don't need to answer questions 9-12 if this person is not applying for coverage.

8. Are you a US citizen or national? ☐ Yes ☐ No

9. If a non-citizen, have you lived in the U.S. for any length of time prior to 08/22/1996? ☐ Yes ☐ No

10. Please provide information on your immigration documentation

If you have an eligible immigration status, please provide information on your documentation below.

Document Type		Document Number	Expiration(MM/DD/YY)
10a. Certificate of Citizenship: Alien #:	☐	Citizenship Number	Not applicable
110b. Naturalization Certificate: Alien #:	☐	Naturalization Number	Not applicable
10c. Reentry Permit (I-327): Alien #:	☐		
10d. Permanent Resident Card ("Green Card," I-551): Alien #:	☐	I-551 Card Number:	
10e. Refugee Travel Document (I-571) Alien #:	☐		
10f. Employment Authorization Card (I-766) Alien #:	☐	I-776 Card Number:	
10g. Machine Readable Immigrant Visa (with temporary I-551 language). Visa Number:_____ Country of Issuance: _____ Alien Number:_____	☐	Passport Number:	
10h. Temporary I-551 Stamp (on passport or I-94, I-94A) Country of Issuance: _____ Alien Number:_____	☐	Passport Number:	
10i. Arrival/Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services Sevis ID: _____	☐	I-94 Number:	
10j. Arrival/Departure Record in unexpired foreign passport (I-94) Country of Issuance: _____ Sevis ID: _____ Visa Number: _____	☐	Passport Number: I-94 Number:	
10k. Unexpired foreign passport Country of Issuance: _____ Sevis ID: _____	☐	Passport Number: I-94 Number:	
10L. Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20) Sevis ID: _____ Country of Issuance: _____	☐	Passport Number: I-94 Number:	
10m. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019) Sevis ID: _____ Country of Issuance: _____	☐	Passport Number: I-94 Number:	
10n. Other documents or status types Document Description:_____ Alien Number:_____ Sevis ID: _____ Country of Issuance: _____	☐	Passport Number: I-94 Number:	

11. If your name is different on your immigration document, please provide the name on the document:

First Name Middle Name Last Name

12. Are you an honorably discharged veteran or an active duty member in the U.S. military? ☐ Yes ☐ No

Family Member 2 - American Indian & Alaskan Native Information

American Indian and Alaskan Natives may be eligible for special benefits through HealthSource RI.

13. Is this person American Indian or an Alaskan Native? ☐ Yes ☐ No (**If NO**, skip to Family Member 3 questions, if applicable.)

If YES:

13a. Is this person a member of a Federally Recognized Tribe? ☐ Yes ☐ No

13b. Tribe Name _____ **13c.** State _____

13d. Has this person ever gotten services from the Indian Health Service, Tribal Health Program or Urban Indian Health Program? ☐ Yes ☐ No

13e. Is this person eligible to get services from the Indian Health Service, Tribal Health Program or Urban Indian Health Program through a referral from one of these programs? ☐ Yes ☐ No

Family Member 3 - *Skip to page 18 if there is no one else in your family*

1. First Name | M.I. | Last Name | Suffix (Sr., Jr., I, II, III, IV)

2. Does this person live with You, the Primary Applicant? ☐ Yes ☐ No

3. If NO, this person's Home Address	Apt/Unit #	City	State	Zip Code

4. Relationship to You, the Primary Applicant:

- ☐ Brother/sister
- ☐ Uncle/aunt
- ☐ First cousin
- ☐ Son-in-law/daughter-in-law
- ☐ Brother-in-law/sister-in-law
- ☐ Trustee
- ☐ Ward
- ☐ Non-relative caretaker
- ☐ Husband/Wife
- ☐ Domestic Partner
- ☐ Former spouse
- ☐ Son/daughter
- ☐ Stepson/stepdaughter
- ☐ Nephew/niece
- ☐ Child of domestic partner
- ☐ Grandchild
- ☐ Adopted son/daughter
- ☐ Foster child
- ☐ Sponsored dependent
- ☐ Parent
- ☐ Stepparent
- ☐ Guardian
- ☐ Father-in-law/ mother-in-law
- ☐ Grandparent
- ☐ Parent's domestic partner

5. Ethnicity (Optional) ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ other Hispanic ☐ non-Hispanic

6. Race (Optional) ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian ☐ Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other

7. Is this person currently incarcerated? ☐ Yes ☐ No

7a. If YES: Expected Release Date: Month:_____ Day:_____ Year:_____

Family Member 3 - Citizenship and Immigration Information

You don't need to answer questions 9-12 if this person is not applying for coverage.

8. Are you a US citizen or national? ☐ Yes ☐ No

9. If a non-citizen, has this person lived in the U.S. for any length of time prior to 08/22/1996? ☐ Yes ☐ No

10. Please provide information on your immigration documentation

If you have an eligible immigration status, please provide information on your documentation below.

Document Type		Document Number	Expiration(MM/DD/YY)
10a. Certificate of Citizenship: Alien #:	☐	Citizenship Number	Not applicable
10b. Naturalization Certificate: Alien #:	☐	Naturalization Number	Not applicable
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10d. Permanent Resident Card ("Green Card," I-551): Alien #:	☐	I-551 Card Number:	
10e. Refugee Travel Document (I-571) Alien #:	☐		
10f. Employment Authorization Card (I-766) Alien #:	☐	I-776 Card Number:	
10g. Machine Readable Immigrant Visa (with temporary I-551 language). Visa Number:_____ Country of Issuance: _____ Alien Number:_____	☐	Passport Number:	
10h. Temporary I-551 Stamp (on passport or I-94, I-94A) Country of Issuance: _____ Alien Number:_____	☐	Passport Number:	
10i. Arrival/Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services Sevis ID: _____	☐	I-94 Number:	
10j. Arrival/Departure Record in unexpired foreign passport (I-94) Country of Issuance: _____ Sevis ID: _____ Visa Number: _____	☐	Passport Number: I-94 Number:	
10k. Unexpired foreign passport Country of Issuance: _____ Sevis ID: _____	☐	Passport Number: I-94 Number:	
10L. Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20) Sevis ID: _____ Country of Issuance: _____	☐	Passport Number: I-94 Number:	
10m. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019) Sevis ID: _____ Country of Issuance: _____	☐	Passport Number: I-94 Number:	
10n. Other documents or status types Document Description:_____ Alien Number:_____ Sevis ID: _____ Country of Issuance: _____	☐	Passport Number: I-94 Number:	

11. If your name is different on your immigration document, please provide the name on the document:

First Name Middle Name Last Name

12. Are you an honorably discharged veteran or an active duty member in the U.S. military? ☐ Yes ☐ No

Family Member 3 - American Indian & Alaskan Native Information

American Indian and Alaskan Natives may be eligible for special benefits through HealthSource RI.

13. Is this person American Indian or an Alaskan Native? ☐ Yes ☐ No (**If NO**, skip to Family Member 4 questions, if applicable.)

If YES:

13a. Is this person a member of a Federally Recognized Tribe? ☐ Yes ☐ No

13b. Tribe Name _____ **13c.** State _____

13d. Has this person ever gotten services from the Indian Health Service, Tribal Health Program or Urban Indian Health Programs? ☐ Yes ☐ No

13e. Is this person eligible to get services from the Indian Health Service, Tribal Health Program or Urban Indian Health Programs through a referral from one of these programs? ☐ Yes ☐ No

Family Member 4 - *Skip to page 18 if there is no one else in your family*

1. First Name | M.I. | Last Name | Suffix (Sr., Jr., I, II, III, IV)

2. Does this person live with You, the Primary Applicant? ☐ Yes ☐ No

3. If NO, this person's Home Address	Apt/Unit #	City	State	Zip Code

4. Relationship to You, the Primary Applicant:

- ☐ Brother/sister
- ☐ Uncle/aunt
- ☐ First cousin
- ☐ Son-in-law/daughter-in-law
- ☐ Brother-in-law/sister-in-law
- ☐ Trustee
- ☐ Ward
- ☐ Non-relative caretaker
- ☐ Husband/Wife
- ☐ Domestic Partner
- ☐ Former spouse
- ☐ Son/daughter
- ☐ Stepson/stepdaughter
- ☐ Nephew/niece
- ☐ Child of domestic partner
- ☐ Grandchild
- ☐ Adopted son/daughter
- ☐ Foster child
- ☐ Sponsored dependent
- ☐ Parent
- ☐ Stepparent
- ☐ Guardian
- ☐ Father-in-law/ mother-in-law
- ☐ Grandparent
- ☐ Parent's domestic partner

5. Ethnicity (Optional) ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ other Hispanic ☐ non-Hispanic

6. Race (Optional) ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian ☐ Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other

7. Is this person currently incarcerated? ☐ Yes ☐ No

7a. If YES: Expected Release Date: Month:_____ Day:_____ Year:_____

Family Member 4 - Citizenship and Immigration Information

You don't need to answer questions 9-12 if this person is not applying for coverage.

8. Are you a US citizen or national? ☐ Yes ☐ No

9. If a non-citizen, has this person lived in the U.S. for any length of time prior to 08/22/1996? ☐ Yes ☐ No

10. Please provide information on your immigration documentation

If you have an eligible immigration status, please provide information on your documentation below.

Document Type		Document Number	Expiration(MM/DD/YY)
10a. Certificate of Citizenship: Alien #:	☐	Citizenship Number	Not applicable
10b. Naturalization Certificate: Alien #:	☐	Naturalization Number	Not applicable
10c. Reentry Permit (I-327): Alien #:	☐		
10d. Permanent Resident Card ("Green Card," I-551): Alien #:	☐	I-551 Card Number:	
10e. Refugee Travel Document (I-571) Alien #:	☐		
10f. Employment Authorization Card (I-766) Alien #:	☐	I-776 Card Number:	
10g. Machine Readable Immigrant Visa (with temporary I-551 language). Visa Number:_____ Country of Issuance: _____ Alien Number:_____	☐	Passport Number:	
10h. Temporary I-551 Stamp (on passport or I-94, I-94A) Country of Issuance: _____ Alien Number:_____	☐	Passport Number:	
10i. Arrival/Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services Sevis ID: _____	☐	I-94 Number:	
10j. Arrival/Departure Record in unexpired foreign passport (I-94) Country of Issuance: _____ Sevis ID: _____ Visa Number: _____	☐	Passport Number: I-94 Number:	
10k. Unexpired foreign passport Country of Issuance: _____ Sevis ID: _____	☐	Passport Number: I-94 Number:	
10L. Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20) Sevis ID: _____ Country of Issuance: _____	☐	Passport Number: I-94 Number:	
10m. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019) Sevis ID: _____ Country of Issuance: _____	☐	Passport Number: I-94 Number:	
10n. Other documents or status types Document Description:_____ Alien Number:_____ Sevis ID: _____ Country of Issuance: _____	☐	Passport Number: I-94 Number:	

11. If your name is different on your immigration document, please provide the name on the document:

First Name Middle Name Last Name

12. Are you an honorably discharged veteran or an active duty member in the U.S. military? ☐ Yes ☐ No

Family Member 4 - American Indian & Alaskan Native Information

American Indian and Alaskan Natives may be eligible for special benefits through HealthSource RI.

13. Is this person American Indian or an Alaskan Native? ☐ Yes ☐ No (**If NO**, skip to Page 18)

If YES:

13a. Is this person a member of a Federally Recognized Tribe? ☐ Yes ☐ No

13b. Tribe Name _____ **13c.** State _____

13d. Has this person ever gotten service from the Indian Health Service, Tribal Health Program or Urban Indian Health Program? ☐ Yes ☐ No

13e. Is this person eligible to get services from the Indian Health Service, Tribal Health Program or Urban Indian Health Program through a referral from one of these programs? ☐ Yes ☐ No

Authorized Representative Information

Selecting an Authorized Representative is optional. You may consider selecting an Authorized Representative if you need or would like help making sure you are aware of important notices or bills for health insurance sent by HealthSource RI. An Authorized Representative should be someone you trust because this person will be the only one who receives certain information from HealthSource RI on your behalf. This person will receive information from HealthSource RI on your behalf. This includes your HealthSource RI notices with important information and your insurance bills. You and your Authorized Representative will both have access to your electronic HealthSource RI account. If you want to name an Authorized Representative, check "Yes" below and enter his or her details. Your authorized representative must be 18 or older and can be a friend, relative, or anyone else you choose.

Do you want to appoint an authorized representative? ☐ Yes ☐ No

If YES, please answer the following questions:

1. Authorized Representative's First Name, Middle Name, Last Name & Suffix (e.g. Sr. Jr., I, II, III, IV, V etc.)

1a. Mailing Address	Apt/Unit #	City	State	Zip Code

1b. Primary Phone Number	**1c.** Secondary Phone Number	**1d.** Email Address
☐ Cell ☐ Other ☐ Work ( )	☐ Cell ☐ Other ☐ Work ( )	

1e. HealthSource RI may need to contact you regarding the status of the application and/or request additional information. Authorized Representative's preferred method of contact ☐ Email ☐ Paper Mail

1f. What is the preferred time of contact (for phone calls)? ☐ Morning ☐ Afternoon ☐ Evening ☐ Weekend ☐ Anytime

1g. Preferred spoken language (lengua hablada preferida)	**1h.** Preferred written language (lenguaje escrito preferido)
☐ English ☐ Español ☐ Português	☐ English ☐ Español ☐ Português

1i. Company/Organization Name (If Applicable)	**1j.** Organization ID (If Applicable)

1k. The **Primary Applicant** must sign below to acknowledge that they have an authorized representative who can make decisions on their behalf.

Signature **X**_____

For Certified Application Counselors, Navigators, Agents, and Brokers Only

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

2. Application start date (MM/DD/YYYY)

2a. First name	Middle Name	Last Name	Suffix (e.g. Sr. Jr., I, II, III, IV, V etc.)

2b. Organization name	**2c.** ID number (if applicable)

Read Carefully Before Signing

YOUR CONSENT TO SHARE DATA FOR ELIGIBILITY DECISIONS

We can help you better if we are able to work with other agencies and professionals that know you and your family. By checking the I Agree box you are giving permission for us to obtain, use and share confidential information about you from a variety of sources including the R.I. Department of Labor and Training, the R.I. Department of Human Services, the R.I. Executive Office of Health and Human Services, the R.I. Department of Health, the R.I. Department of Corrections, and Experian on behalf of Centers for Medicaid and Medicare Services and Social Security Administration.

We will not refuse you any benefits or access to any programs that you are eligible simply because you do not give us permission to obtain, use and share confidential information, however, we are unable to assist you in accessing certain programs and supports that you may be eligible for if we do not have your consent to obtain and share information. Your consent is required in order to determine your eligibility.

You can proceed to shop for and purchase health insurance coverage without completing this consent by contacting our Contact Center at 1-855-840-HSRI (4774), but if you would like to know whether you are eligible for any financial support for the purchase of coverage, whether you are eligible for publicly funded coverage, or other programs and supports, it will be necessary for you to complete this consent.

All information sharing and use that you are authorizing by checking the I Agree box will be done in compliance with all relevant federal and state laws and regulations protecting your privacy, including but not limited to: The Health Insurance Portability and Accounting Act of 1996 (Pub. L. 104-191 known as HIPAA); The R.I. Confidentiality of Health Care Communications and Information (R.I.G.L. 5-37.3-1 et seq.); R.I.G.L. 28-32-5, 28-36-12, 28-42-38, 28-39-19, 28-39-22, 40.1-5-26, 23-3-23, 42-12-22, 40-6-12 and all other applicable laws and regulations. Information will be shared by computer data transfer.

By checking on the I Agree box I consent to the obtaining and use of confidential information about me to determine my eligibility for enrollment in publicly funded health insurance coverage or other publicly funded programs administered through this site, plan, provide, and coordinate benefits and payments.

☐ I Agree to give my Consent to Share Data for Eligibility Decisions

☐ I do not agree to this Consent and understand that my eligibility for certain programs and supports will be impacted by this decision

I have read or had explained to me my rights and responsibilities and understand that I may keep a copy of the HealthSource RI *Rights and Responsibilities* (listed on pages 3-5 of this application). ☐ Yes ☐ No

Declaration and Signature

I have read and understood the information in this application. By signing this document, I certify under penalty of perjury that my answers are correct, including information about citizenship and alien status, and complete to the best of my knowledge. I also acknowledge the following:

- I understand the questions and statements on this application. If I do not understand, I know that I can get help and get answers to my questions by calling HealthSource RI at 1-855-840-4774.
- I understand the penalties for providing false information or breaking the rules.
- I understand that the agency may contact other persons or organizations.
- I know that under the state of Rhode Island General Laws, Section 40-6-15, a maximum fine of $1,000, or inprisonment of up to five (5) years, or both, may be imposed for a person who obtains or attempts to obtain, or aids or abets any person to obtain, public assistance to which he or she is not entitled or who willfully fails to report income, resources, or personal circumstances or increases therein which exceed the amount previously reported.

Under penalty of perjury, I attest to the identity of the minor children identified herein and that all of the information contained in this application is true. I understand that I am breaking the law if I give wrong information and can be punished under federal law, state law or both.

Signature	**Date**
Spouse's Signature	**Date**

HealthSourceRI
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF HUMAN SERVICES

RHODE ISLAND
VOTER REGISTRATION FORM

Please print clearly in ink. All information is required unless marked optional.

YOU MAY USE THIS FORM TO:

- Register to vote in Rhode Island.
- Change your name and/or address on your registration.
- Choose a political party or change parties.

TO REGISTER TO VOTE IN RI YOU MUST BE:

- A legal resident of Rhode Island.
- A citizen of the United States.
- At least 16 years of age.
  (You must be at least 18 years of age to vote on Election Day.)

INSTRUCTIONS

Box 2: REQUIRED. Rhode Island citizens who are at least 16 years of age may pre-register to vote using this form. If you fail to check either of these boxes, this form will be returned to you. If you checked NO to either of these statements, do not complete this form.

Box 3: If you are registering to vote for the first time in Rhode Island by mail or if someone else turns this form in for you, it is **REQUIRED** that you provide your driver's license number or state ID number issued by the RI Department of Motor Vehicles (DMV). If you do not have either, you must provide the last 4 digits of your Social Security Number. If you do not provide the above information or it cannot be verified, you will be required to provide identification to an election official before voting. Acceptable forms of identification are on the Board of Elections website at http://www.elections.ri.gov or contact your local Board of Canvassers (see reverse side of this form).

Box 5: A person may have only one legal residence. You must register from your legal residence. A post office box or rural route may only be used as a "Mailing Address" in Box 6.

Box 9: If you want to affiliate to vote, choose a party. If you leave Box 9 blank, you will be listed as unaffiliated.

Box 10: You must SIGN and DATE the registration form. If you fail to sign and date the form, it will be returned to you.

Box 11: If you are updating your voter registration because you legally changed your name, enter your previous legal name.

Box 12: If you are updating your voter registration because of an address change, enter your previous address, **even if out-of-state.**

You will receive an acknowledgement receipt of this voter registration form within 3 weeks. If you do not receive it, contact your local Board of Canvassers (see reverse side for list). For questions and deadlines relating to this form, visit the Board of Elections website at http://www.elections.ri.gov or contact your local Board of Canvassers (see reverse side for list).

(This form may be reproduced)

1. Check Boxes that Apply: ☐ New Voter Registration ☐ Address Change ☐ Party Change ☐ Name Change

2. I am a U.S. Citizen and resident of Rhode Island. ☐ Yes ☐ No

I am at least 16 years of age. (You must be at least 18 years of age to vote.) ☐ Yes ☐ No

If you checked NO to either of these statements, do not complete this form.

3. RI driver's license or ID Number: _____

If you do not have a RI driver's license or ID, enter last 4 digits of your social security number: _____

If you do not enter either number, see instructions for Box 3.

4. Last Name	Suffix (if any)	First Name	Middle Name (or initial)

5. Home Address (Do not enter a post office box)	Apt.	City/Town	State	ZIP Code
			RI	

6. Mailing Address (If different from Box 5)	Apt.	City/Town	State	ZIP Code

7. Date of Birth (mm/dd/yyyy)

Month Day Year

8. Phone No./ E-mail Address (optional)

9. Party Affiliation: ☐ Democrat ☐ Moderate ☐ Republican ☐ Unaffiliated ☐ Other_____

10. I swear or affirm that:

- I am not incarcerated in a correctional facility upon a felony conviction.
- I am not presently judged "mentally incompetent" to vote by a court of law.
- The information I have provided is true to the best of my knowledge under penalty of perjury. If I have provided false information, I may be fined, imprisoned, or (if not a U.S. citizen) deported from or refused entry into the United States.

Official Use For Barcode

PLEASE SIGN FULL NAME OR PLACE MARK BELOW

Signed _____ **Date:** _____ **(mm/dd/yyyy)**

Are you interested in working at the polls? (check box below) ☐

Warning: If you sign this form and know it to be false, you can be convicted and fined up to $5,000 or jailed up to 10 years.

11. PREVIOUS NAME (if different from Box 4)

12. PREVIOUS ADDRESS OF REGISTRATION (City/Town, State, ZIP & County)

02/2012 Regs
Form Revised 12/2012

Return Address

_____

_____

_____

Postage Required Post Office will not deliver without proper postage.

Mail To: **BOARD OF CANVASSERS**

_____

_____

_____

**********FOLD HERE & TAPE AT TOP**********

INSTRUCTIONS FOR MAILING THE VOTER REGISTRATION FORM

An applicant who chooses to mail his/her voter registration form shall do so in the following manner:

1. Fold the form at the dotted line and tape the bottom to the top of the form.
2. From the list below, locate the address of the board of canvassers in the city or town in which you are registering to vote and insert that address in the appropriate space beneath "**Mail To: BOARD OF CANVASSERS"** on the addressed side of the voter registration form. Insert your return address in the space provided.

NOTICE: *It is against the law for anyone to interfere with your privacy in registering to vote or in choosing a political party. If you believe someone has interfered with your right to register or not register, or with your privacy in making this decision, or in choosing a political party, you may file a complaint with the State Board of Elections, 50 Branch Avenue, Providence, Rhode Island 02904.*

LOCAL BOARDS OF CANVASSERS

Barrington Town Hall, 283 County Rd., Barrington, RI 02806

Bristol Town Hall, 10 Court St., Bristol, RI 02809

Burrillville Town Hall, 105 Harrisville Main St., Harrisville, RI 02830

Central Falls City Hall, 580 Broad St.., Central Falls, RI 02863

Charlestown Town Hall, 4540 S. County Trail, Charlestown, RI 02813

Coventry Town Hall, 1670 Flat River Rd., Coventry, RI 02816

Cranston City Hall, 869 Park Ave., Cranston, RI 02910

Cumberland Town Hall, 45 Broad St., Cumberland, RI 02864

East Greenwich Town Hall, PO Box 111, East Greenwich, RI 02818

East Providence City Hall, 145 Taunton Ave., East Providence, RI 02914

Exeter Town Hall, 675 Ten Rod Rd., Exeter, RI 02822

Foster Town Hall, 181 Howard Hill Rd., Foster, RI 02825

Glocester Town Hall 1145 Putnam Pike PO Drawer B, Glocester, RI 02814

Hopkinton Town Hall, 1 Town House Rd., Hopkinton, RI 02833

Jamestown Town Hall, 93 Narragansett Ave., Jamestown, RI 02835

Johnston Town Hall, 1385 Hartford Ave., Johnston, RI 02919

Lincoln Town Hall, 100 Old River Rd., PO Box 100, Lincoln, RI 02865

Little Compton Town Hall, PO Box 226, Little Compton, RI 02837

Middletown Town Hall, 350 East Main Rd., Middletown, RI 02842

Narragansett Town Hall, 25 Fifth Ave., Narragansett, RI 02882

New Shoreham Town Hall, PO Drawer, 220 Block Island, RI 02807

Newport City Hall, 43 Broadway, Newport, RI 02840

N. Kingstown Town Hall, 80 Boston Neck Rd., North Kingstown, RI 02852

North Providence Town Hall, 2000 Smith St., North Providence, RI 02911

North Smithfield Municipal Annex, 575 Smithfield Rd., North Smithfield, RI 02896

Pawtucket City Hall, 137 Roosevelt Ave., Pawtucket, RI 02860

Portsmouth Town Hall, 2200 East Main Rd., Portsmouth, RI 02871

Providence City Hall, 25 Dorrance St., Providence, RI 02903

Richmond Town Hall, 5 Richmond Townhouse Rd., Wyoming, RI 02898

Scituate Town Hall, PO Box 328, North Scituate, RI 02857

Smithfield Town Hall, 64 Farnum Pike, Smithfield, RI 02917

S. Kingstown Town Hall, 180 High St., Wakefield, RI 02879

Tiverton Town Hall, 343 Highland Rd., Tiverton, RI 02878

Warren Town Hall, 514 Main St., Warren, RI 02885

Warwick City Hall, 3275 Post Rd., Warwick, RI 02886

W. Greenwich Town Hall 280 Victory Highway, W. Greenwich, RI 02817

West Warwick Town Hall, 1170 Main St., West Warwick, RI 02893

Westerly Town Hall, 45 Broad St., Westerly, RI 02891

Woonsocket City Hall, P.O. Box B, 169 Main St., Woonsocket, RI 02895

Voter Registration Questions May Be Addressed To:

Rhode Island Board of Elections
50 Branch Avenue
Providence, RI 02904
elections@elections.ri.gov